

		FOR OFF USE					

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2005  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2005)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0033159</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>																																																																															
<b>Facility Name:</b> <u>Clinton Manor Living Center</u>		<p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/05</u> to <u>12/31/05</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p>																																																																															
<b>Address:</b> <u>111 East Illinois Street</u> <u>New Baden</u> <u>62265</u>																																																																																	
<div>NumberCityZip Code</div>																																																																																	
<b>County:</b> <u>Clinton</u>																																																																																	
<b>Telephone Number:</b> <u>618-588-4924</u> <b>Fax #</b> ( <u>  </u> )																																																																																	
<b>IDPA ID Number:</b> <u>371224393001</u>		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Type or Print Name) _____</td><td></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Title) _____</td><td></td></tr><tr><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>James G. Hull</u> <u>Vice President</u></td><td></td></tr><tr><td>(Firm Name &amp; Address) <u>WDM Computer Services, Inc.</u> <u>1900 Harrison, Quincy, IL 62301</u></td><td></td></tr><tr><td colspan="2"><b>Date of Initial License for Current Owners:</b> <u>01/01/88</u></td><td colspan="2">(Telephone) <u>217-228-1950</u> Fax # <u>217-222-6053</u></td></tr><tr><td colspan="2"><b>Type of Ownership:</b></td><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr><tr><td colspan="2"><table><tr><td><input type="checkbox"/></td><td><b>VOLUNTARY, NON-PROFIT</b></td><td><input type="checkbox"/></td><td><b>PROPRIETARY</b></td><td><input type="checkbox"/></td><td><b>GOVERNMENTAL</b></td></tr><tr><td><input type="checkbox"/></td><td>Charitable Corp.</td><td><input type="checkbox"/></td><td>Individual</td><td><input type="checkbox"/></td><td>State</td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td><input type="checkbox"/></td><td>Partnership</td><td><input type="checkbox"/></td><td>County</td></tr><tr><td colspan="2"><b>IRS Exemption Code</b> _____</td><td><input type="checkbox"/></td><td>Corporation</td><td><input type="checkbox"/></td><td>Other _____</td></tr><tr><td colspan="2"></td><td><input checked="" type="checkbox"/></td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>Other</td><td colspan="2">_____</td></tr></table></td><td colspan="2"></td></tr><tr><td colspan="2"><b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>James G. Hull</u> <b>Telephone Number:</b> <u>217-228-1950</u></td><td colspan="2"></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) _____		Paid Preparer	(Title) _____		(Signed) _____	(Date) _____	(Print Name and Title) <u>James G. Hull</u> <u>Vice President</u>		(Firm Name & Address) <u>WDM Computer Services, Inc.</u> <u>1900 Harrison, Quincy, IL 62301</u>		<b>Date of Initial License for Current Owners:</b> <u>01/01/88</u>		(Telephone) <u>217-228-1950</u> Fax # <u>217-222-6053</u>		<b>Type of Ownership:</b>		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630		<table><tr><td><input type="checkbox"/></td><td><b>VOLUNTARY, NON-PROFIT</b></td><td><input type="checkbox"/></td><td><b>PROPRIETARY</b></td><td><input type="checkbox"/></td><td><b>GOVERNMENTAL</b></td></tr><tr><td><input type="checkbox"/></td><td>Charitable Corp.</td><td><input type="checkbox"/></td><td>Individual</td><td><input type="checkbox"/></td><td>State</td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td><input type="checkbox"/></td><td>Partnership</td><td><input type="checkbox"/></td><td>County</td></tr><tr><td colspan="2"><b>IRS Exemption Code</b> _____</td><td><input type="checkbox"/></td><td>Corporation</td><td><input type="checkbox"/></td><td>Other _____</td></tr><tr><td colspan="2"></td><td><input checked="" type="checkbox"/></td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>Other</td><td colspan="2">_____</td></tr></table>		<input type="checkbox"/>	<b>VOLUNTARY, NON-PROFIT</b>	<input type="checkbox"/>	<b>PROPRIETARY</b>	<input type="checkbox"/>	<b>GOVERNMENTAL</b>	<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State	<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County	<b>IRS Exemption Code</b> _____		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other _____			<input checked="" type="checkbox"/>	"Sub-S" Corp.	_____				<input type="checkbox"/>	Limited Liability Co.	_____				<input type="checkbox"/>	Trust	_____				<input type="checkbox"/>	Other	_____				<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>James G. Hull</u> <b>Telephone Number:</b> <u>217-228-1950</u>			
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#	0033159	Report Period Beginning:	01/01/05	Ending:	12/31/05
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**D. How many bed-hold days during this year were paid by the Department?**

**375** (Do not include bed-hold days in Section B.)

**E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)**

**n/a**

**F. Does the facility maintain a daily midnight census?** Yes

YES ☒ NO ☐

YES ☒ NO ☐

**Date started** 01/01/88

YES ☐ Date \_\_\_\_\_ NO ☒

YES ☒ NO ☐ If YES, enter number

of beds certified	33	and days of care provided	12,045
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**Medicare Intermediary      Mutual of Omaha**

ACCRUAL	<input checked="" type="checkbox"/>	MODIFIED	<input type="checkbox"/>	CASH*	<input type="checkbox"/>
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Is your fiscal year identical to your tax year? YES ☒ NO ☐

**Tax Year:** 12/31/05      **Fiscal Year:** 12/31/05

**\* All facilities other than governmental must report on the accrual basis.**

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	61	42	1,057	1,160	8
9	SNF/PED					9
10	ICF	7,414	2,742		10,156	10
11	ICF/DD	17,649			17,649	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,124	2,784	1,057	28,965	14

**C. Percent Occupancy.** (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **95.61%**

Facility Name & ID Number      Clinton Manor Living Center      #      0033159      Report Period Beginning:      01/01/05      Ending:      12/31/05

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	169,459	11,399	4,909	185,767		185,767	(589)	185,178			1
2	Food Purchase		151,029		151,029		151,029	(1,832)	149,197			2
3	Housekeeping	94,017	15,465	2,360	111,842		111,842		111,842			3
4	Laundry	53,628	11,374	25	65,027		65,027		65,027			4
5	Heat and Other Utilities			69,490	69,490		69,490		69,490			5
6	Maintenance	52,298	9,969	64,869	127,136	3,976	131,112	(150)	130,962			6
7	Other (specify):*							(12,000)	(12,000)			7
8	<b>TOTAL General Services</b>	369,402	199,236	141,653	710,291	3,976	714,267	(14,571)	699,696			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			5,500	5,500		5,500		5,500			9
10	Nursing and Medical Records	1,377,868	49,181	146,751	1,573,800		1,573,800	(40,925)	1,532,875			10
10a	Therapy			170,992	170,992		170,992		170,992			10a
11	Activities	23,117	19,314		42,431		42,431		42,431			11
12	Social Services	113,213		1,975	115,188		115,188	(25,654)	89,534			12
13	CNA Training											13
14	Program Transportation	36,992		24,381	61,373		61,373		61,373			14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	1,551,190	68,495	349,599	1,969,284		1,969,284	(66,579)	1,902,705			16
	<b>C. General Administration</b>											
17	Administrative	120,936		24,000	144,936		144,936		144,936			17
18	Directors Fees											18
19	Professional Services			104,038	104,038	(3,481)	100,557	(96,000)	4,557			19
20	Dues, Fees, Subscriptions & Promotions			40,484	40,484	(17)	40,467	(21,909)	18,558			20
21	Clerical & General Office Expenses	96,681	6,689	25,271	128,641	(495)	128,146	(22,384)	105,762			21
22	Employee Benefits & Payroll Taxes			343,722	343,722		343,722		343,722			22
23	Inservice Training & Education			7,770	7,770		7,770		7,770			23
24	Travel and Seminar			7,216	7,216	(94)	7,122	(782)	6,340			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			50,850	50,850		50,850		50,850			26
27	Other (specify):*			1,934	1,934	94	2,028		2,028			27
28	<b>TOTAL General Administration</b>	217,617	6,689	605,285	829,591	(3,993)	825,598	(141,075)	684,523			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,138,209	274,420	1,096,537	3,509,166	(17)	3,509,149	(222,225)	3,286,924			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name & ID Number Clinton Manor Living Center #0033159 Report Period Beginning: 01/01/05 Ending: 12/31/05

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			93,984	93,984		93,984	(1,504)	92,480			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			96,320	96,320		96,320	(92)	96,228			32
33	Real Estate Taxes			20,841	20,841		20,841		20,841			33
34	Rent-Facility & Grounds					1,049	1,049		1,049			34
35	Rent-Equipment & Vehicles			3,593	3,593	(1,049)	2,544		2,544			35
36	Other (specify):*			5,708	5,708	17	5,725	(5,708)	17			36
37	<b>TOTAL Ownership</b>			220,446	220,446	17	220,463	(7,304)	213,159			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		46,860	6,148	53,008		53,008		53,008			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		13,303		13,303		13,303		13,303			41
42	Provider Participation Fee			45,443	45,443		45,443		45,443			42
43	Other (specify):*			683	683		683		683			43
44	<b>TOTAL Special Cost Centers</b>		60,163	52,274	112,437		112,437		112,437			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,138,209	334,583	1,369,257	3,842,049		3,842,049	(229,529)	3,612,520			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,832)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(12,000)	7		6
7	Sale of Supplies to Non-Patients	(678)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	22	30		9
10	Interest and Other Investment Income	(92)	32		10
11	Discounts, Allowances, Rebates & Refunds	(589)	1		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(587)	36		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(255)	36		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(21,909)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(776)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(142,051)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (180,747)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ (180,747)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Fees	\$ (741)	36	1
2	Amortization of Lona Costs	(1,967)	36	2
3	Political Contributions	(1,382)	36	3
4	CSS Labor:Admin Progr.	(25,654)	12	4
5	CSS Labor:Admin Asst.	(22,384)	21	5
6	CSS Labor:Nursing	(40,247)	10	6
7	CSS Labor: Maintenance	(150)	6	7
8	Non-care Related Depreciation	(1,526)	30	8
9	Related Party Management Fees	(24,000)	19	9
10	Related Party Management Fees	(24,000)	19	10
11	2004 Seminar Expenses	(200)	24	11
12	Unsubstantiated Seminar Expenses	(582)	24	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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44				44
45				45
46				46
47				47
48				48
49	Total	(142,833)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Clinton Manor Living Center

# 0033159

Report Period Beginning:

01/01/05

Ending:

12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	(589)	0	0	0	0	0	0	0	0	0	0	(589)	1
2	Food Purchase	(1,832)	0	0	0	0	0	0	0	0	0	0	(1,832)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(150)	0	0	0	0	0	0	0	0	0	0	(150)	6
7	Other (specify):*	(12,000)	0	0	0	0	0	0	0	0	0	0	(12,000)	7
8	<b>TOTAL General Services</b>	<b>(14,571)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(14,571)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(40,925)	0	0	0	0	0	0	0	0	0	0	(40,925)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(25,654)	0	0	0	0	0	0	0	0	0	0	(25,654)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(66,579)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(66,579)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(48,000)	(48,000)	0	0	0	0	0	0	0	0	0	(96,000)	19
20	Fees, Subscriptions & Promotions	(21,909)	0	0	0	0	0	0	0	0	0	0	(21,909)	20
21	Clerical & General Office Expenses	(22,384)	0	0	0	0	0	0	0	0	0	0	(22,384)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(782)	0	0	0	0	0	0	0	0	0	0	(782)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(93,075)</b>	<b>(48,000)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(141,075)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(174,225)</b>	<b>(48,000)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(222,225)</b>	<b>29</b>

## Summary B

**12/31/05**

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Michael Brave	25			Brave Inc.	New Baden	Management
Ann Reis	25	Carlyle Healthcare Center	Carlyle	DAR Mngmt	Quincy	Management
		St. Vincent's Home. Inc.	Quincy	Wdm Computer Servi	Quincy	Data Processing
Blain Richard	25	St. Ann's Healthcare Center, Inc.	Chester	RDR Mngmt	Albers	Management
Michael & Gail Greer	25	St. Ann's Healthcare Center, Inc.	Chester	Greer Mngmt	Trenton	Management
		O'Fallon Healthcare Center, Inc.	O'Fallon			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Management	\$ 24,000	Brave Mangement	0.00%	\$	\$ (24,000)	1
2	V	19	Management	24,000	DAR Management	0.00%		(24,000)	2
3	V	19	Data Processing	18,269	WDM Computer Services, Inc.	0.00%	18,269		3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 66,269			\$ 18,269	\$ * (48,000)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Clinton Manor Living Center # 0033159 Report Period Beginning: 01/01/05 Ending: 12/31/05

# **VII. RELATED PARTIES (continued)**

## **C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.**

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Michael Greer	Vice President	Owner	25.00	0	14	33.00	Wages	\$ 14,372	17-1	1
2	Blain Richard	President	Owner	25.00	0	10	25.00	Wages	14,400	17-1	2
3	Ann Reis	n/a	Owner	25.00	0	0	0.00	n/a	0	17-1	3
4	Dave Reis	Treasurer	Board Member	0.00	0	10	25.00	Wages	14,400	17-1	4
5	Michael Brave	Administrator	Administrator	25.00	0	40	100.00	Wages	77,764	17-1	5
6	RDR Mngmt	Management	Management	0.00	0	5	12.00	Mngt Fees	24,000	19-3	6
7	DAR Mngt	Management	Management	0.00	0	5	12.00	Mngt Fees	24,000	19-3	7
8	Greer Mngt	Management	Management	0.00	0	5	12.00	Mngt Fees	24,000	19-3	8
9	Brave, Inc.	Management	Management	0.00	0	5	12.00	Mngt Fees	24,000	17-3	9
10	See Attatched List (Pg 28)										10
11											11
12											12
13								TOTAL	\$ 216,936		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Clinton Manor Living Center # 0033159 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
Street Address \_\_\_\_\_  
City / State / Zip Code \_\_\_\_\_  
Phone Number (\_\_\_\_) \_\_\_\_\_  
Fax Number (\_\_\_\_) \_\_\_\_\_

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8		9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	First National Bank		X	Mortgage	\$12,930.02	10/3/01	\$ 1,325,000	\$ 916,883	10/15/06		\$ 40,727	1		
2	First National Bank		X	Refinance	\$924.82	01/03/02	100,000	72,922	12/03/06	7.2500	8,022	2		
3	Ford Credit		X	Auto Loan	\$633.45	04/03/03	38,007	17,737	04/03/08	0.0000		3		
4	First National Bank		X	Contruction Loan	\$1,308.32	12/19/03	95,000	82,344	05/19/09	7.2500	5,450	4		
5	First National Bank		X	Auto Loan	\$174.00	11/30/05	7,254	7,254	11/23/09	5.9000	28	5		
	Working Capital													
6	Cash Flow		X	Liability Insurance Pymt	Various	02/11/04	53,500	4,864	01/11/06		1,610	6		
7	Cash Flow		X	Cash Flow	Various	10/15/03	225,000	300,000	12/31/06	7.2500	16,483	7		
8	Owners	X		Cash Flow	Interest	04/13/97	48,000	400,000	12/31/06	6.0000	24,000	8		
9	TOTAL Facility Related					\$15,970.61		\$ 1,891,761	\$ 1,802,003			\$ 96,320	9	
	B. Non-Facility Related*													
10												10		
11												11		
12												12		
13												13		
14	TOTAL Non-Facility Related							\$	\$			\$	14	
15	TOTALS (line 9+line14)							\$ 1,891,761	\$ 1,802,003			\$ 96,320	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

3. Under or (over) accrual (line 2 minus line 1).

4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.  
(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.  
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

200018,9418

200119,6079

200219,70310

200320,13711

200419,20912

FOR OHF USE ONLY

13FROM R. E. TAX STATEMENT FOR 2004\$13

14PLUS APPEAL COST FROM LINE 5\$14

15LESS REFUND FROM LINE 6\$15

16AMOUNT TO USE FOR RATE CALCULATION \$16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Clinton Manor Living Center COUNTY Clinton

FACILITY IDPH LICENSE NUMBER 0033159

CONTACT PERSON REGARDING THIS REPORT James G. Hull

TELEPHONE 217-228-1950 FAX #: 217-222-6053

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 11-10-18-178-002	Sec 18 TWP 1 Rng 5 lot 57 58 & 59	\$ 18,159.84	\$ 18,159.84
2. 11-10-18-175-023	New Baden pt of Lot 54 & 55	\$ 2,097.42	\$ 2,097.42
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 20,257.26	\$ 20,257.26

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

21,794

B. General Construction Type:

Exterior

Brick

Frame

Wood,Steel & Concret

Number of Stories

1

C. Does the Operating Entity?

X

(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

X

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

X

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	26,669	1987	\$ 66,000	1
2					2
3	TOTALS	26,669		\$ 66,000	3

XI. OWNERSHIP COSTS (continued)											
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	69		1987	1969	\$ 594,000	\$ 19,800	30	\$ 19,800	\$	\$ 356,404	4
5	12		1991	1991	511,306	17,096	30	17,044	(52)	242,037	5
6											6
7											7
8											8
	Improvement Type**										
9	SPRINKLER		1990		3,140	158	20	157	(1)	2,392	9
10	LAND IMPROVEMENT		1992		5,410		10			5,410	10
11	BUILDING IMPROVEMENT		1992		37,505	1,629	20,10	1,620	(9)	26,507	11
12	BUILDING IMPROVEMENT		1992		26,098	1,312	20	1,305	(7)	17,024	12
13	CON		1992		3,000		30	100	100	1,400	13
14	BUILDING IMPROVEMENT		1994		12,580	296	20,10	294	(2)	10,164	14
15	PLUMBING		1995		12,200	613	20	610	(3)	6,529	15
16	LANDSCAPING		1997		1,675	167	10	168	1	1,438	16
17	BOILER		1997		8,858	366	8	366		8,858	17
18	REMODEL OF DINING ROOM		1997		35,389	1,769	20	1,769		14,303	18
19	HEETING/COOLING SYSTEM		1999		13,826	1,384	10	1,383	(1)	8,521	19
20	FIRE ALARM UPGRADE		2001		2,610	261	10	261		1,066	20
21	FRONT ADDITION		2001		115,835	5,792	20	5,792		23,651	21
22	DINING ROOM REMODEL		2001		84,135	4,207	20	4,207		17,179	22
23	Kitchen Improvements		2004		3,852	197	20	193	(4)	312	23
24	Flooring		2004		2,790	279	10	279		349	24
25	Laundry Building		2004		106,437	5,322	20	5,322		7,539	25
26	Bathroom Flooring		2005		3,650	137	20	137		137	26
27	Concrete		2005		2,367	99	10	99		99	27
28	Flooring		2005		3,032	63	20	63		63	28
29	Bathroom Remodel		2005		3,550	44	20	44		44	29
30	Roof Repairs		2005		4,225	71	20	71		71	30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,597,470	\$ 61,062		\$ 61,084	\$ 22	\$ 751,497	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 177,338	\$ 20,668	\$ 20,668	\$	10	\$ 84,294	71
72	Current Year Purchases	31,051	1,376	1,376		10	1,376	72
73	Fully Depreciated Assets	288,111				10	288,103	73
74								74
75	TOTALS	\$ 496,500	\$ 22,044	\$ 22,044	\$		\$ 373,773	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Station Wagon	1993	\$ 8,401	\$	\$	\$	3	\$ 8,401	76
77	Facility	03 Ford Van	2003	40,507	8,102	8,102		5	22,279	77
78	Facility	Van	1999	37,719				5	37,719	78
79	See List	See List	See List	13,440	1,250	1,250		5	1,343	79
80	TOTALS			\$ 100,067	\$ 9,352	\$ 9,352	\$		\$ 69,742	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,260,037	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 92,458	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 92,480	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 22	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,195,012	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Office Building	\$ 45,776	\$ 1,526	\$ 13,097	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 45,776	\$ 1,526	\$ 13,097	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

YES

☒NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease

9. Option to Buy:

YESNO

Terms: \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☒ YESNO
16. Rental Amount for movable equipment: \$ 2,544Description: Dishwasher (\$1,389.72), Tank Rental (\$24.09), Maint Equip Renal (\$1130.00)

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	10-3	visits			4,348			4,348	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	10-3	hrs		215	10,726		215	10,726	10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	215	\$ 15,074	\$	215	\$ 15,074	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 9,776	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	961,541		3
4	Supply Inventory (priced at <u>Fifo</u> )	19,268		4
5	Short-Term Investments			5
6	Prepaid Insurance	33,012		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Rounding</u>	1		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,023,598	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	10,921		12
13	Land	116,387		13
14	Buildings, at Historical Cost	2,184,030		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	601,450		16
17	Accumulated Depreciation (book methods)	(1,382,847)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>CIP</u>	7,491		22
23	Other(specify): <u>Loan Origination Fees</u>	989		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,538,421	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,562,019	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 178,574	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	300,000		29
30	Accrued Salaries Payable	147,975		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,086		31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,584		32
33	Accrued Interest Payable	4,545		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Wage Garnisemnt</u>	198		36
37	<u>Ins. Withheld</u>	(3,892)		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 663,070	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	512,198		39
40	Mortgage Payable	1,214,066		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 1,726,264	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,389,334	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 172,685	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,562,019	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 99,785	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 99,785	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	109,897	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(48,551)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Income/(loss) From Rental Properties	11,554	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 72,900	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 172,685	24 *

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 3,704,616	1
2	Discounts and Allowances for all Levels	(21,645)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,682,971	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	85,979	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 85,979	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education	20,721	9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	11,494	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,832	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	150	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 34,197	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	92	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 92	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See List Attached</u>	148,707	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 148,707	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,951,946	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	710,291	31
32	Health Care	1,969,284	32
33	General Administration	829,591	33
	<b>B. Capital Expense</b>		
34	Ownership	220,446	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	66,994	35
36	Provider Participation Fee	45,443	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,842,049	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	109,897	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 109,897	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	3,884	4,176	\$ 103,816	\$ 24.86	1
2	Assistant Director of Nursing	3,904	4,226	84,224	19.93	2
3	Registered Nurses	2,715	2,766	56,686	20.49	3
4	Licensed Practical Nurses	14,320	15,156	259,003	17.09	4
5	CNAs & Orderlies	18,547	19,532	214,116	10.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,884	2,012	23,117	11.49	9
10	Activity Assistants					10
11	Social Service Workers	4,000	4,225	50,200	11.88	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,900	2,199	31,845	14.48	14
15	Cook Helpers/Assistants	9,681	10,386	93,275	8.98	15
16	Dishwashers	6,191	6,404	44,340	6.92	16
17	Maintenance Workers	3,850	4,375	52,298	11.95	17
18	Housekeepers	10,777	11,358	94,017	8.28	18
19	Laundry	6,461	7,053	53,628	7.60	19
20	Administrator	1,880	2,088	77,764	37.24	20
21	Assistant Administrator					21
22	Other Administrative			43,172		22
23	Office Manager					23
24	Clerical	5,930	6,590	96,681	14.67	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	8,162	8,465	116,377	13.75	28
29	Resident Services Coordinator	1,856	2,088	63,013	30.18	29
30	Habilitation Aides (DD Homes)	53,353	56,566	543,645	9.61	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Transportation	2,990	3,478	36,992	10.64	33
34	TOTAL (lines 1 - 33)	162,285	173,143	\$ 2,138,209 *	\$ 12.35	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	102	\$ 4,909	1-3	35
36	Medical Director	Contract	5,500	9-3	36
37	Medical Records Consultant	18	630	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	1,800	39-3	39
40	Physical Therapy Consultant	Contract	107,110	10a-1	40
41	Occupational Therapy Consultant	Contract	48,655	10a-1	41
42	Respiratory Therapy Consultant	Contract	41	10-3	42
43	Speech Therapy Consultant	Contract	15,228	10a-1	43
44	Activity Consultant				44
45	Social Service Consultant	37	1,975	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	157	\$ 185,848		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	335	\$ 9,457	10-3	50
51	Licensed Practical Nurses	1,190	36,776	10-3	51
52	Certified Nurse Assistants/Aides	1,695	32,512	10-3	52
53	TOTAL (lines 50 - 52)	3,219	\$ 78,745		53

Facility Name &amp; ID Number      Clinton Manor Living Center

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Michael Brave	Administrator	25	\$ 77,764
Blain Richard	Owner	25	14,400
Michael Greer	Owner	25	14,372
Dave Reis	Owner	25	14,400
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 120,936
B. Administrative - Other			
Description			Amount
Brave Management			\$ 24,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 24,000
C. Professional Services			
Vendor/Payee	Type		Amount
RDR Management	Management Svcs		\$ 24,000
Greer Management	Management Svcs		24,000
DAR Magagement	Management Svcs		24,000
Giffen,Winning, Bodewes	Legal		8,267
CMS	Medicare Billing		719
Hartford	Benefit Administration		1,086
WDM Computer Services	Data Processing		18,269
Stephanie Kavanaugh	Consulting		216
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 100,557
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 96,375
Unemployment Compensation Insurance			26,916
FICA Taxes			157,181
Employee Health Insurance			57,318
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
401 (k) Match			2,377
Deffered Compensation			3,500
Employee Physical			55
TOTAL (agree to Schedule V, line 22, col.8)			\$ 343,722
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
N/A			\$ 0
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			10,727
Health Care Worker Background Check (Indicate # of checks performed 50 )			800
Promo/PR			21,909
See List Attatched			4,331
Drug Testing			2,700
Less: Public Relations Expense			(21,909)
Non-allowable advertising			(
Yellow page advertising			(
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 18,558
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
See List Attached			6,340
Seminar Expense			
Entertainment Expense			(
(agree to Sch. V, line 24, col. 8)			\$ 6,340

**\* Attach copy of IMRF notifications**

**\*\*See instructions.**

**(See instructions.)**

[illegible]

Facility Name &amp; ID Number    Clinton Manor Living Center

#    0033159

Report Period Beginning:    01/01/05

Ending:    12/31/05

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. ICHA, \$2195.50
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.    \$ 7,243 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.    \$ 45,443  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.    \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,832
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period.    \$ 0  
c. What percent of all travel expense relates to transportation of nurses and patients? 75  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**g. Does the facility transport residents to and from day training?** No  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

Clinton Manor Living Center, Inc.  
01/01/05 thru 12/31/05  
0033159

The following is a breakdown of Schedule V Line 23 Column 3

Vendor	Purpose	Expense
O'Fallon Healthcare	ORCA Training	\$1,605.87
Greer Mgmt	ORCA Training	\$593.19
G. Neil	Training books	\$129.05
Walden Books	Software Training Books	\$169.94
Rob Blatner	People MAP Training	\$1,085.00
Ramada Inn	Rob Blatner Hotel	\$122.26
Walmart	Training Supplies	\$74.20
Franklin Covey	Training Supplies	\$56.59
Washington County	CPR Cards	\$24.00
Washington County	CPR Class Rental	\$20.00
WRS	Training Supplies	\$335.64
Rob Blatner	People MAP Training	\$1,020.00
Sam's Club	Training Supplies	\$42.02
Ramada Inn	Rob Blatner Hotel	\$88.91
Amazon.com	People MAP Training Supplies	\$19.17
Network Connection	People MAP Training Supplies	\$18.95
Interlock Pharmacy	Self-Training Fee	\$75.00
Chann	HCP Tool Kit	\$88.72
Rob Blatner	People MAP Training	\$1,055.00
Ramada Inn	Rob Blatner Hotel	\$138.14
American Healthcare	Luncheon	\$49.45
G.Neil	Annual Service Fee	\$44.99
Quill	DSP Training Supplies	\$45.10
Venture	DD Day Training Supplies	\$55.45
Sharon Pfieffer	DSP Training Supplies	\$24.56
G. Neil	USFRRR Poster & paperwork	\$30.86
Quill	DSP Training Supplies	\$187.27
Quill	Departmental Training Supplie	\$88.15
Office Depot	Training Supplies	\$51.39
Borders	Training books	\$12.89
Med Pass	Infection Control Manual	\$196.24
Quill	Annual Training Supplies	\$63.58
Prog	Day Training Supplies	\$18.99
G. Neil	Posters	\$22.09
Rita Hicks	DD Book	\$39.95
Credit Card	Training Supplies	\$76.90
		<u>\$7,769.51</u>

Clinton Manor Living Center, Inc.  
01/01/05 thru 12/31/05  
0033159

The following is a breakdown of Schedule V Line 6 Column 3

Repairs & Maint. Dietary	\$1,174.71
Repairs & Maint. Laundry	\$2,725.87
Repairs & Maint. Housekeeping	\$210.29
Repairs & Maint. Equipment	\$10,969.94
Repairs & Maint. Ground	\$9,705.72
Repairs & Maint. Building	\$20,523.90
Repairs & Maint. Wheelchairs	\$648.95
Repairs & Maint. Outside services	\$17,358.82
Repairs & Maint. Gen/Amdin.	\$5,531.52

\$68,844.72

The following is a breakdown of Schedule V Line 21 Column 3

Printing	\$1,223.63
Postage	\$3,584.76
Software Support	\$5,940.00
Copies	\$2,392.61
Telephone	\$11,634.99

\$24,775.99

The following is a breakdown of Schedule V Line 36 Column 3

Sales Tax	\$587.00
State Replacement Tax	\$776.00
Contributions	\$255.00
Bank & service fees	\$740.81
Amortization of Loan Costs	\$1,967.30
Bad Debt Expense	\$0.00
Political Contributions	\$1,398.40
Rounding	

\$5,724.51

The following is a breakdown of Schedule XVII Line 28a

CSS Labor: Admin. Program	\$26,654.40
CSS Labor: Admin. Assist.	\$22,384.44
CSS Labor: Nursing Labor	\$40,247.28
CSS Labor: Maintenance	\$150.00
Misc. Revenue	\$5,255.81
Personal Purchases Income	\$528.58
Office Lease	\$12,000.00
Rebates	\$559.17
Discounts	\$0.00
In-House Day Training Revenue	\$41,013.52
Gain/Loss on Sale of Asset	\$200.00
Acct-Chcks	\$25.18
Income from Transpo (IDPA Trans. Paymt	-\$340.40
Rounding	-\$1.00

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The following is a breakdown of Schedule XIX, Section F

IMDA Dues	\$200.00
Illinois Health Care Association Dues	\$2,195.50
Sam's Club	\$270.00
Chamber of Commerce	\$100.00
Ill Dept of Professional Regulation	\$372.00
AAMP Dues	\$135.00
DMA Dues	\$122.00
Misc Subscriptions	\$159.40
Food Svc License	\$105.00
Vehicle Licenses	\$673.00
Rounding	-\$1.00

\$4,330.90

Schedule XIII, Section A.

Chn's are responsible for their own training and testing.

2003 Long term Real Estate Tax Statement

Section B :

Part of the office building is rented out to another corporation. That rent is then taken of the cost report.

Schedule XI, Section D Line 79

Use	Make	Mod	Year	AcquiCost	Current	S/L Degrec	Life	Accum Degrec
Facility	St.	Wagon	2005	\$7,942.50	\$132.37	\$132.37		5 \$132.37
Facility	Used	Truck	2004	<u>\$5,497.27</u>	<u>\$1,118.00</u>	<u>\$1,118.00</u>		5 <u>\$1,211.00</u>
				<u>#####</u>	<u>\$1,250.37</u>	<u>\$1,250.37</u>		<u>\$1,343.37</u>

Schedule V, Line 24 Column 3

[illegible]

Clinton Manor Living Center, Inc.

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Schedule VII Attatchment

Name	Function	Nursing Home	Compensation	
			Ownership Interest	from other Nursing Homes
RDR Management	Management	St. Ann's Healthcare Ctr.	0	33000
Greer Management	Management	St. Ann's Healthcare Ctr.	0	33000
Greer Management	Management	O'Fallon Healthcare Ctr.	0	
Mike Greer	Owner	O'Fallon Healthcare Ctr.	100	
Mike Greer	Owner	St. Ann's Healthcare Ctr.	26	
Gail Greer	Owner	St. Ann's Healthcare Ctr.	24	
Roger Richard Marita	Owner	St. Ann's Healthcare Ctr.	19	
Blain Richard	Owner	St. Ann's Healthcare Ctr.	31	
Dar Mngt	Management	Southern Illinois Comm. Suppor	0	18337
Greer Management	Management	Southern Illinois Comm. Suppor	0	18337
Advanced Options	Management	Southern Illinois Comm. Suppor	0	36674
RDR Management	Management	Southern Illinois Comm. Suppor	0	18337

Clinton Manor Living Center, Inc.  
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The following is a breakdown of the reclassifications:

1. \$1049.00 From Line 35 to Line 34 due to reclassification of Storage Rent.
2. Reclassify \$495 from line 21 to line 19 due to coding error.
- 3 Reclassify Computer repairs & Maint of 3975.96 out of line 19 to line 6.
- 4 Reclassify Political Dues of \$16.60 out of line 20 into line 36
- 5 Reclassify \$93.95 of meeting Exp. From Seminar to line 27-3

Clinton Manor Living Center, Inc.  
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Patient days

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Private	248	212	238	230	217	256	345	223	224	187	185	219	2784
IDPA	689	631	609	630	619	563	506	693	629	638	627	641	7475
IDPA-Res	10	14	28	11	0	3	21	17	0	0	0	0	104
DD	1418	1267	1446	1484	1541	1493	1520	1547	1495	1511	1453	1474	17649
DD-Res	23	21	43	16	9	7	20	3	5	40	47	37	271
Medicare		55	118	86	125	155	111	88	40	32	72	93	975
Medicare-Co Ins.	43									39			82
	2431	2200	2482	2457	2511	2477	2523	2571	2393	2447	2384	2464	29340